SECTION 8

Post-acute care

Skilled nursing facilities
Home health services
Inpatient rehabilitation facilities
Long-term care hospitals

Chart 8-1. Number of post-acute care providers decreased slightly or remained stable in 2014

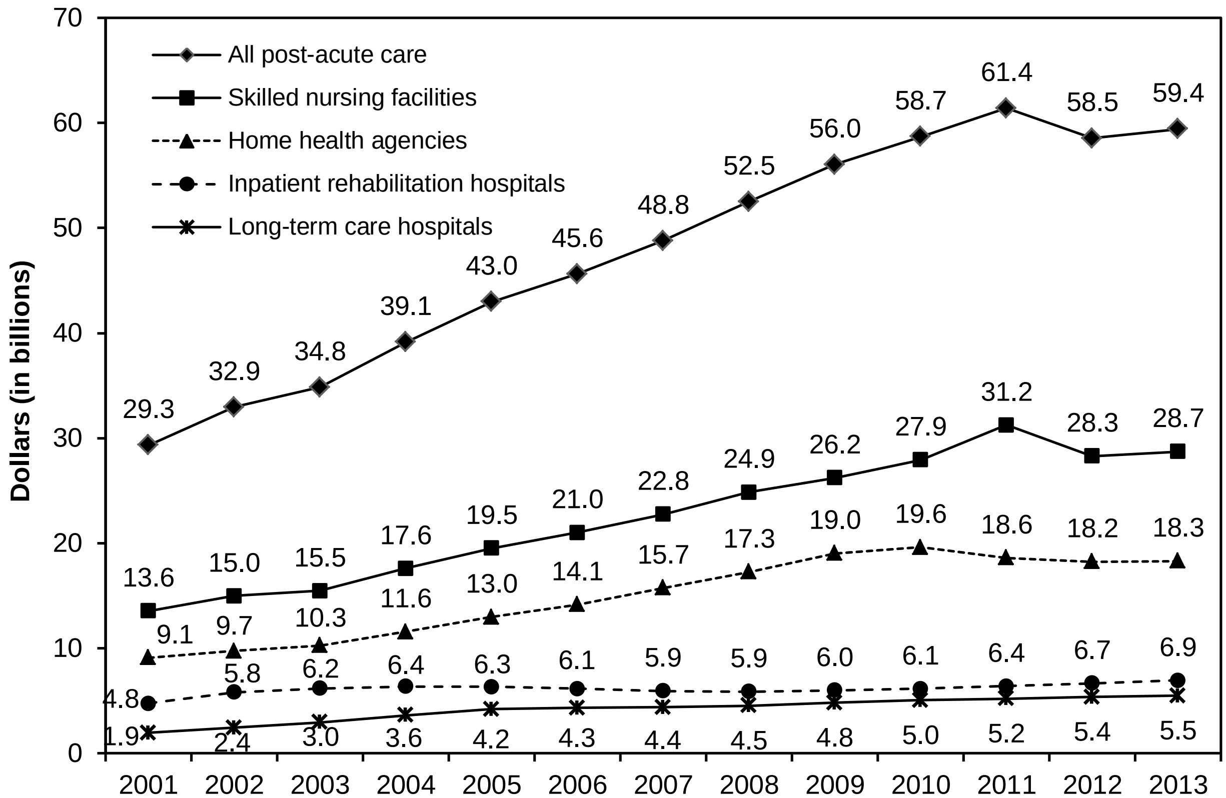
	2005	2007	2009	2011	2013	2014	Average annual percent change 2005–2013	Percent change 2013–2014
Home health agencies	8,314	9,404	10,961	12,026	12,613	12,461	5.3%	–1.2%
Inpatient rehabilitation facilities	1,235	1,202	1,196	1,165	1,161	1,177	–0.6	1.4
Long-term care hospitals	388	396	427	437	432	422	1.4	–2.3
Skilled nursing facilities	15,026	15,047	15,062	15,120	15,163	15,173	0.1	0.1

Note: The skilled nursing facility count does not include swing beds.

Source: MedPAC analysis of data from the Provider of Services files from CMS.

- The number of home health agencies declined slightly in 2014, though this decline comes after several years of substantial growth. The decline in agencies was concentrated in Texas and Florida, two states that have seen considerable growth since the implementation of the prospective payment system in October 2000.
- In spite of a moratorium on new long-term care hospitals (LTCHs) beginning in October 2007, the number of these facilities continued to grow through 2011. The number of LTCHs has since decreased from 437 in 2011 to 422 in 2014.
- The total number of skilled nursing facilities has increased slightly since 2005, and the mix of facilities shifted from hospital-based to freestanding facilities. In 2013, hospital-based facilities made up 5 percent of all facilities, down from 8 percent in 2005.

Chart 8-2. Home health care and skilled nursing facilities have fueled growth in Medicare's post-acute care expenditures



Note: These numbers are program spending only and do not include beneficiary copayments.

Source: CMS Office of the Actuary, 2015.

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- Increases in fee-for-service (FFS) spending on post-acute care have slowed in part because of expanded enrollment in managed care under Medicare Advantage; Medicare Advantage spending is not included in this chart.

- FFS spending on inpatient rehabilitation hospitals declined from 2005 through 2008, reflecting policies intended to ensure that patients who do not need this intensity of services are treated in less-intensive settings. However, spending on inpatient rehabilitation hospitals has increased since 2009.

- FFS spending on skilled nursing facilities increased sharply in 2011, reflecting CMS's adjustment for the implementation of the new case-mix groups (resource utilization groups, version IV) beginning October 2010. Once CMS established that the adjustment it made was too large, it lowered the adjustment, and spending dropped in 2012.

Chart 8-3. Freestanding SNFs and for-profit SNFs account for the majority of facilities, Medicare stays, and Medicare spending

	Facilities		Medicare-covered stays		Medicare payments (billions)	
Type of SNF	2006	2013	2006	2013	2006	2013
Totals	15,178	14,978	2,454,263	2,365,743	$19.5	$26.6
Freestanding	92%	95%	89%	94%	94%	97%
Hospital based	8	5	11	6	6	3
Urban	67	72	79	83	81	85
Rural	33	28	21	17	19	15
For profit	68	70	67	71	73	75
Nonprofit	26	25	29	25	24	21
Government	5	5	4	3	3	3

Note: SNF (skilled nursing facility). Totals may not sum to 100 due to rounding and missing values.

Source: MedPAC analysis of the Provider of Services and Medicare Provider Analysis and Review files, 2006 and 2013.

- The mix of where beneficiaries receive SNF services has shifted toward freestanding, urban, and for-profit facilities.
- In 2013, freestanding facilities accounted for 94 percent of stays and an even larger share of Medicare's payments (97 percent).
- In 2013, urban facilities accounted for 72 percent of facilities, 83 percent of stays, and 85 percent of Medicare payments.
- In 2013, for-profit facilities accounted for 70 percent of facilities, but proportionally higher shares of stays and Medicare payments (71 percent and 75 percent, respectively).

Chart 8-4. SNF service use continued to decline between 2012 and 2013

Volume measure	2006	2008	2010	2012	2013	Percent change 2012–2013
Covered admissions per 1,000 FFS beneficiaries	72	73	72	68	67	–2.2%
Covered days (in thousands)	1,892	1,977	1,938	1,861	1,835	–1.4
Covered days per admission	26.3	27.0	27.1	27.4	27.6	0.7

Note: SNF (skilled nursing facility), FFS (fee-for-service). Data include 50 states and the District of Columbia. Yearly figures presented in the table are rounded, but percent change column was calculated using unrounded data.

Source: Calendar year data from CMS, Office of Information Products and Data Analytics 2013.

- In 2013, 4.5 percent of beneficiaries used SNF services, down slightly from 2011 (not shown).
- Between 2012 and 2013, admissions per 1,000 FFS beneficiaries decreased 2.2 percent, paralleling the decline in inpatient hospital use. An acute hospital stay of three or more days is a prerequisite for Medicare coverage of SNF care.
- Covered days declined at a slower pace (1.4 percent), resulting in a slight increase in covered days per admission (0.7 percent).

Chart 8-5. Freestanding SNF Medicare margins remain high despite reductions in payments

	2002	2004	2006	2008	2010	2012	2013
All	17.5%	13.8%	12.8%	16.7%	19.4%	14.0%	13.1%
Rural	20.3	16.1	13.5	17.9	19.4	13.0	12.1
Urban	16.9	13.3	12.7	16.4	19.4	14.2	13.3
Nonprofit	9.1	3.8	3.2	7.2	10.8	5.7	5.0
For profit	19.4	16.1	15.1	19.0	21.5	16.2	15.3

Note: SNF (skilled nursing facility).

Source: MedPAC analysis of freestanding SNF cost reports 2002–2013.

- Though lower than in recent years, the 2013 Medicare margin for freestanding SNFs exceeded 10 percent for the 14th consecutive year. The 2013 margin is lower than the 2012 margin for two reasons: current law requires market basket increases to be offset by a productivity adjustment and sequestration began lowering payments in April 2013 by 2 percent on an annualized basis.

- In 2013, on average, urban facilities had slightly higher Medicare margins than rural facilities even though rural facilities have higher base rates than urban facilities. For-profit SNFs had higher Medicare margins than nonprofit SNFs.

- In 2013, total margins (the margin across all payers and all lines of business) for freestanding facilities remained positive and increased slightly from 2012 (1.9 percent, up from 1.8 percent in 2012, not shown).

Chart 8-6. Cost and payment differences explain variation in Medicare margins for freestanding SNFs in 2013

Characteristic	Highest margin quartile (*n* = 3,238)	Lowest margin quartile (*n* = 3,238)	Ratio of highest quartile to lowest quartile
Cost measures			
Standardized cost per day	$250	$359	0.7
Standardized cost per discharge	$11,116	$13,591	0.8
Average daily census (patients)	88	68	1.3
Average length of stay (days)	46	37	1.3
Revenue measures			
Medicare payment per day	$474	$424	1.1
Medicare payment per discharge	$22,391	$15,790	1.4
Share of days in intensive therapy	82%	73%	1.1
Share of medically complex days	4	6	0.7
Medicare share of facility revenue	26	16	1.6
Patient characteristics			
Case-mix index	1.39	1.30	1.1
Share of dual-eligible of beneficiaries	40%	27%	1.5
Share of minority beneficiaries	13	4	3.3
Share of very old beneficiaries	30	36	0.8
Medicaid share of days	66	58	1.1
Facility mix			
Percent for profit	90%	60%	N/A
Percent urban	76	68	N/A

Note: SNF (skilled nursing facility), N/A (not applicable). Values shown are medians for the quartile. Highest margin quartile SNFs were in the top 25 percent of the distribution of Medicare margins. Lowest margin quartile SNFs were in the bottom 25 percent of the distribution of Medicare margins. Standardized costs per day are Medicare costs adjusted for differences in area wages and the case mix (using the nursing component's relative weights) of Medicare beneficiaries. "Intensive therapy days" are days classified into ultra-high and very-high rehabilitation case-mix groups. Quartile figures presented in the table are rounded, but the ratio column was calculated using unrounded data.

Source: MedPAC analysis of freestanding SNF cost reports 2013.

- Medicare margins varied widely across freestanding SNFs. One-quarter of SNFs had Medicare margins at or below 3.7 percent, and one-quarter of facilities had Medicare margins at or above 21.7 percent (data not shown).

- High-margin SNFs had lower costs per day (30 percent lower costs than low-margin SNFs), after adjusting for wage and case-mix differences, and higher revenues per day (1.1 times the revenues per day of low-margin SNFs).

- Facilities with the highest Medicare margins had higher case-mix indexes, higher shares of beneficiaries who were dually eligible for Medicare and Medicaid, and higher shares of minority beneficiaries.

Chart 8-7. Financial performance of relatively efficient SNFs reflects a combination of lower cost per day and higher payments per day

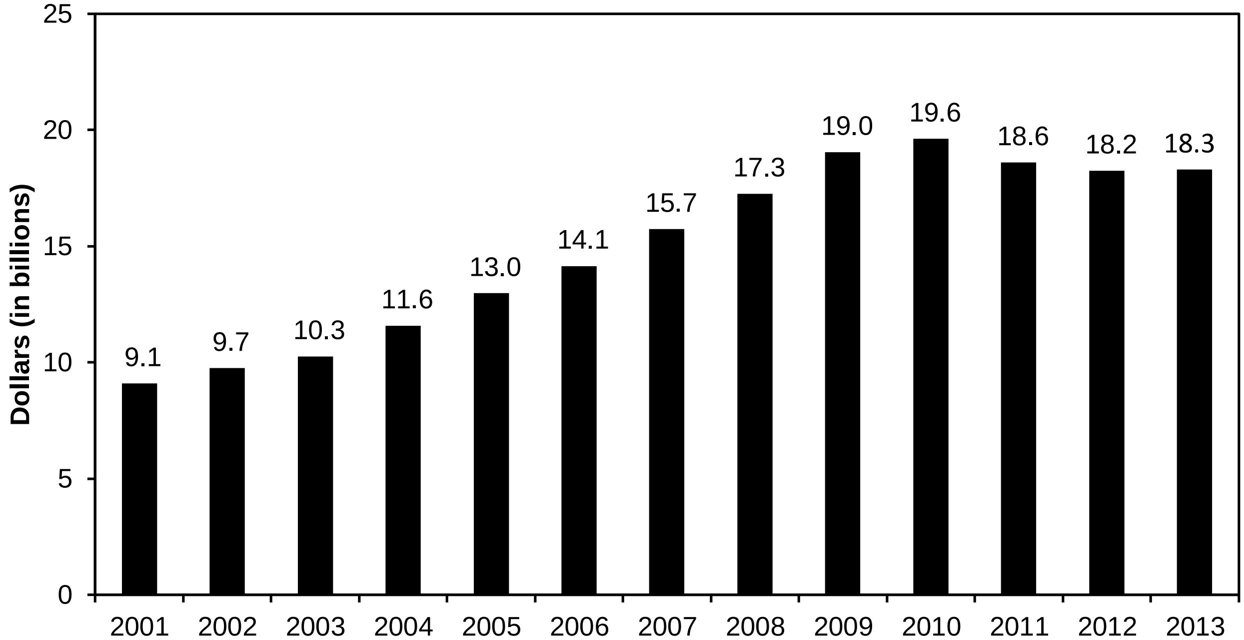
	Relatively efficient SNFs	All SNFs
Performance in 2013		
Community discharge rate	48%	40%
Rehospitalization rate	9%	11%
Standardized cost per day	$272	$293
Medicare revenue per day	$487	$458
Medicare margin	20.6%	14.5%
Total margin	3.5%	2.1%
Facility case-mix index	1.42	1.37
Medicare average length of stay	33 days	37 days
Occupancy rate	88%	87%
Number of beds	120	117
Share of intensive therapy days	82%	80%
Share of medically complex days	5%	5%
Medicaid share of facility days	58%	61%
Share of urban	81%	74%
Share of for profit	83%	75%

Note: SNF (skilled nursing facility). The analysis includes 7,928 freestanding facilities. SNFs were defined as efficient by their cost per day (2010–2012) and two quality measures (community discharge and rehospitalization rates) for the same period. Efficient SNFs were those in the best third of the distribution of one measure and not in the bottom third on any measure in each of three years. Seven percent of SNFs qualified as relatively efficient. Costs per day were standardized for differences in case mix (using the nursing component relative weights) and wages. Quality measures were rates of risk-adjusted community discharge and rehospitalization for patients with potentially avoidable conditions within 100 days of hospital discharge. Quality measures were calculated for all facilities with at least 25 stays. Intensive therapy days include days classified into the ultra-high and very-high case-mix groups. Medically complex days were defined as those assigned to clinically complex or special-care case-mix groups.

Source: MedPAC analysis of quality measures for 2010–2013 and Medicare cost report data for 2010–2013.

- Relatively efficient SNFs were defined as consistently providing relatively low-cost and high-quality care compared with other SNFs.
- Compared with national averages, relatively efficient SNFs furnished considerably higher quality (higher discharge to community rates and lower readmission rates) and had costs per day that were 7 percent lower.

Chart 8-8. Spending on home health care, 2001–2013



Source: CMS Office of the Actuary.

- In October 2000, the prospective payment system (PPS) replaced the previous Medicare payment system. At the same time, eligibility for the benefit broadened slightly.
- Home health care spending has risen rapidly under the PPS. Spending rose by about 10 percent per year between 2001 and 2009; spending peaked in 2010 and has remained relatively flat since 2011.

Chart 8-9. Trends in the provision of home health care

	2002	2012	2013	Percent change 2012–2013	Cumulative percent change 2002–2013
Number of users (in millions)	2.5	3.4	3.5	0.9%	37.8%
Percent of beneficiaries who used home health care	7.2%	9.2%	9.3%	0.5	28.9
Episodes (in millions)	4.1	6.7	6.7	–0.5	63.6
Episodes per home health patient	1.6	2.0	1.9	–1.4	18.7
Visits per home health episode	18.4	16.9	16.5	–2.4	–12.7
Visits per home health patient	31.0	33.1	32.1	3.0	3.5
Average payment per episode	$2,335	$2,677	$2,674	–0.1	14.5

Source: MedPAC analysis of the home health standard analytic file. Yearly figures presented in the table are rounded, but percent change columns were calculated using unrounded data.

- Under the prospective payment system, in effect since October 2000, the number of users and the number of episodes have risen significantly. In 2013, 3.5 million beneficiaries used the home health benefit.
- The number of home health episodes increased rapidly from 2002 to 2013, though growth has slowed in recent years. The number of beneficiaries using home health care has also increased since 2002, but at a lower rate than the growth in episodes.
- The number of visits per episode decreased from 2002 to 2013. However, this decline was offset by an increase in the average number of episodes per patient, which increased from 1.6 in 2002 to 1.9 in 2013. Beneficiaries received fewer visits in an episode but had more 60-day episodes of care. As a result, the average number of visits increased from 31 visits per home health user in 2002 to over 32 visits per home health user in 2013.

Chart 8-10. Home health episodes not preceded by a hospitalization accounted for the majority of services in 2012

	Number of episodes (in millions)		Cumulative	Share of episodes	
	2001	2012	growth	2001	2012
Episodes not preceded by a hospitalization or PAC stay:					
First	0.8	1.4	76%	20%	21%
Subsequent	1.3	3.1	141	32	45
Subtotal	2.1	4.5	116	53	66
Episodes preceded by a hospitalization or PAC stay:					
First	1.6	1.8	17	40	27
Subsequent	0.3	0.5	63	8	7
Subtotal	1.9	2.3	23	47	34
Total	3.9	6.8	72	100%	100%

Note: PAC (post-acute care). "First" indicates no home health episode in the 60 days preceding the episode. "Subsequent" indicates the episode started within 60 days of the end of a preceding episode. "Episodes not preceded by a hospitalization or PAC stay" indicates that there was no hospitalization or PAC stay in the 15 days before the start of the episode. "Episodes preceded by a hospitalization or PAC stay" indicates the episode occurred less than 15 days after a stay in a hospital (including a long-term care hospital), skilled nursing facility, or inpatient rehabilitation facility. The number of episodes presented in the table are rounded, but the cumulative growth column was calculated using unrounded data. Numbers may not sum due to rounding.

Source: CMS Datalink file 2012.

- The rise in the average number of episodes per beneficiary coincides with a relative shift away from using home health care as a PAC service.

- During the 2001 through 2012 period, the number of episodes not preceded by a hospitalization or PAC stay increased by 116 percent compared with a 23 percent increase in episodes that were preceded by a hospitalization or PAC stay. During that period, the share of all episodes preceded by a hospitalization or PAC stay rose from about 53 percent to 66 percent.

- Beneficiaries for whom the majority of home health episodes in 2010 were preceded by a hospitalization or other post-acute stay had different characteristics than community-admitted beneficiaries. Community-admitted home health users were more likely to be dually eligible for Medicare and Medicaid, had more home health episodes, and had more episodes with a high share of home health aide services compared with post-acute users of home health (not shown in table). Community-admitted users generally had fewer chronic conditions, tended to be older, and were more likely to have dementia and Alzheimer's disease.

Chart 8-11. Medicare margins for freestanding home health agencies

	2012	2013	Percent of agencies 2013
All	14.5%	12.7%	100%
Geography			
Mostly urban	14.9	13.1	84
Mostly rural	12.8	11.0	16
Type of control			
For profit	15.3	13.7	89
Nonprofit	14.5	10.0	11
Volume quintile			
First	7.1	6.1	20
Second	8.1	7.8	20
Third	10.1	8.9	20
Fourth	13.2	11.2	20
Fifth	16.8	14.8	20

Note: Agencies are characterized as urban or rural based on the residence of the majority of their patients. Agencies with outlier payments that exceeded 10 percent of Medicare revenues are excluded from the reported statistics.

Source: MedPAC analysis of 2012–2013 Medicare Cost Report files from CMS.

- In 2013, freestanding home health agencies (HHAs) (about 85 percent of all HHAs) had an aggregate margin of 12.7 percent. HHAs that served mostly urban patients in 2013 had an aggregate margin of 13.1 percent; HHAs that served mostly rural patients had an aggregate margin of 11.0 percent. The 2013 margin is consistent with the historically high margins the home health industry has experienced under the prospective payment system. The margin from 2001 to 2012 averaged 17.5 percent (data not shown), indicating that most agencies have been paid well in excess of their costs under the prospective payment system.

- For-profit agencies in 2013 had an average margin of 13.7 percent, and nonprofit agencies had an average margin of 10.0 percent.

- Agencies that serve more patients have higher margins. The agencies in the lowest volume quintile in 2013 have an aggregate margin of 6.1 percent, while those in the highest quintile have an aggregate margin of 14.8 percent.

Chart 8-12. Number of IRF FFS patients was stable in 2013

	2004	2011	2012	2013	Average annual percent change 2004–2012	Percent change 2012–2013
Number of IRF cases	495,000	371,000	373,000	373,000	–3.5%	0.0%
Cases per 10,000 FFS beneficiaries	135.6	101.7	100.1	99.7	–3.7	–0.4
Payment per case	$13,290	$17,398	$17,995	$18,258	3.9	1.5
Average length of stay (in days)	12.7	13.0	12.9	12.9	0.3	–0.4

Note: IRF (inpatient rehabilitation facility), FFS (fee-for-service). Numbers of cases reflect Medicare FFS utilization only. Yearly figures presented in the table are rounded, but percent change columns were calculated using unrounded data.

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

- The number of Medicare FFS IRF cases grew rapidly throughout the 1990s and the early years of the IRF prospective payment system, reaching a peak of about 495,000 in 2004.
- After CMS renewed its enforcement of the compliance threshold in 2004, IRF volume declined substantially. Between 2004 and 2008 (data not shown), the number of IRF cases fell almost 8 percent per year. After 2008, volume began in increase slowly. Between 2012 and 2013, volume was stable, remaining at about 373,000 cases.
- In recent years, the number of IRF cases per 10,000 FFS beneficiaries has held steady at about 100. Relatively few Medicare beneficiaries use IRF services because, to qualify for Medicare coverage, IRF patients must be able both to tolerate and benefit from intensive rehabilitation therapy, which typically consists of at least three hours of therapy a day for at least five days a week.
- Medicare payments per IRF case rose almost 4 percent per year between 2004 and 2012. Payments per case grew 1.5 percent between 2012 and 2013.

Chart 8-13. Most common types of inpatient rehabilitation facility cases, 2013

Type of case	Share of cases
Stroke	19.4%
Fracture of the lower extremity	12.5
Neurological disorders	12.4
Debility	10.2
Major joint replacement of lower extremity	9.0
Brain injury	8.2
Other orthopedic conditions	7.7
Cardiac conditions	5.4
Spinal cord injury	4.6
All other	10.5

Note: "Fracture of the lower extremity" includes hip, pelvis, and femur fractures. "Neurological disorders" includes multiple sclerosis, Parkinson's disease, and polyneuropathy. Patients with debility have generalized deconditioning not attributable to other conditions. "Other orthopedic conditions" excludes fractures of the hip, pelvis, and femur and hip and knee replacements. "All other" includes conditions such as amputations, major multiple trauma, and pain syndrome. Numbers may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Inpatient Rehabilitation Facility–Patient Assessment Instrument data from CMS.

- In 2013, the most frequent diagnosis for Medicare patients in inpatient rehabilitation facilities (IRFs) was stroke, representing almost 20 percent of cases.
- Major joint replacement cases represented 9 percent of IRF admissions in 2013, down from 24 percent in 2004, when major joint replacement was the most common IRF Medicare case type.
- The share of cases represented by patients with neurological disorders has been steadily increasing since 2004, while the share of major joint replacement cases has been steadily decreasing. The share of neurological disorders exceeded the share of major joint replacement for the first time in 2012 and continued in 2013.

Chart 8-14. Inpatient rehabilitation facilities' Medicare margin by type of facility, 2004–2013

	2004	2006	2008	2010	2011	2012	2013
All IRFs	16.7%	12.3%	9.3%	8.7%	9.9%	11.3%	11.4%
Hospital based	12.2	9.6	3.8	–0.4	–0.2	0.8	0.3
Freestanding	24.7	17.4	18.1	21.3	23.2	24.0	24.1
Urban	17.0	12.6	9.5	9.0	10.3	11.7	11.8
Rural	13.2	10.1	6.9	4.8	5.3	6.5	6.4
Nonprofit	12.8	10.6	5.2	2.2	2.7	2.4	1.5
For profit	24.4	16.3	16.8	19.6	20.8	23.0	23.4

Note: IRF (inpatient rehabilitation facility).

Source: MedPAC analysis of cost report data from CMS.

- Between 2012 and 2013, the aggregate IRF Medicare margin remained almost static, rising from 11.3 percent to 11.4 percent, including the effects of the sequester. The aggregate margin has risen steadily since 2009, after a period of declining, though healthy, margins.

- Medicare margins in freestanding IRFs far exceeded those of hospital-based facilities. However, a quarter of hospital-based IRFs had Medicare margins greater than 10 percent (data not shown), indicating that many hospitals can manage their IRF units profitably. Further, despite the comparatively low average margin in hospital-based IRFs, evidence suggests that these units make a positive financial contribution to their parent hospitals. In 2013, the aggregate Medicare margin for acute care hospitals with IRF units was a percentage point higher than the margin of hospitals without IRF units (data not shown).

- Margins also varied by ownership, with for-profit IRFs having substantially higher margins.

- Higher unit costs were the primary driver of lower margins in both hospital-based and nonprofit IRFs (data not shown).

Chart 8-15. Low standardized costs lead to high margins for both hospital-based and freestanding IRFs, 2013

Characteristic	Lowest cost quartile	Highest cost quartile
Median cost per discharge		
All	$11,227	$21,934
Hospital based	12,127	21,848
Freestanding	10,632	22,514
Median Medicare margin		
All	26.2%	–26.0%
Hospital based	21.6	–26.0
Freestanding	29.5	–23.1
Median		
Number of beds	44	17
Occupancy rate	70%	47%
Case-mix index	1.27	1.22
Share of facilities in the quartile that are:		
Hospital based	41%	5%
Freestanding	59	5
Nonprofit	31	63
For profit	65	21
Government	4	16
Urban	93	71
Rural	7	29

Note: IRF (inpatient rehabilitation facility). Cost per discharge is standardized for differences in wages across geographic areas and differences in case mix across providers.

Source: MedPAC analysis of Medicare cost report and Medicare Provider Analysis and Review data from CMS.

- IRFs with the lowest standardized costs (those in the lowest cost quartile) had a median standardized cost per discharge that was almost half that of the IRFs with the highest standardized costs (those in the highest cost quartile).

- IRFs in the lowest cost quartile had a median Medicare margin of 26.2 percent compared with –26.0 percent for IRFs in the highest cost quartile.

- IRFs with the lowest costs tended to be larger: The median number of beds was 44 compared with 17 in the highest cost quartile. In addition, IRFs with the lowest costs had a higher median occupancy rate (70 percent vs. 47 percent). These results suggest that low-cost IRFs benefit from economies of scale.

- Low-cost IRFs were disproportionately freestanding and for profit. Still, 41 percent of IRFs in the lowest cost quartile were hospital based and 31 percent were nonprofit. By contrast, in the highest cost quartile, 95 percent were hospital based and almost two-thirds were nonprofit.

Chart 8-16. The top 25 MS–LTC–DRGs made up two-thirds of LTCH discharges in 2013

MS–LTC –DRG	Description	Discharges	Percentage
207	Respiratory system diagnosis with ventilator support 96+ hours	16,221	11.8%
189	Pulmonary edema and respiratory failure	15,179	11.0
871	Septicemia without ventilator support 96+ hours with MCC	8,458	6.1
177	Respiratory infections and inflammations with MCC	4,324	3.1
592	Skin ulcers with MCC	3,650	2.6
208	Respiratory system diagnosis with ventilator support <96 hours	3,135	2.3
949	Aftercare with CC/MCC	3,003	2.2
539	Osteomyelitis with MCC	2,877	2.1
190	Chronic obstructive pulmonary disease with MCC	2,439	1.8
682	Renal failure with MCC	2,292	1.7
919	Complications of treatment with MCC	2,235	1.6
559	Aftercare, musculoskeletal system and connective tissue with MCC	2,123	1.5
314	Other circulatory system diagnoses with MCC	2,038	1.5
862	Postoperative and post-traumatic infections with MCC	2,026	1.5
193	Simple pneumonia and pleurisy with MCC	1,979	1.4
4	Tracheostomy with ventilator support 96+ hours or primary diagnosis except face, mouth, and neck without major OR	1,925	1.4
166	Other respiratory system OR procedures with MCC	1,917	1.4
870	Septicemia with ventilator support 96+ hours	1,817	1.3
570	Skin debridement with MCC	1,711	1.2
291	Heart failure and shock with MCC	1,664	1.2
853	Infectious and parasitic diseases with OR procedure with MCC	1,556	1.1
981	Extensive OR procedure unrelated to principal diagnosis with MCC	1,541	1.1
638	Diabetes with CC	1,447	1.0
560	Aftercare, musculoskeletal system and connective tissue with CC	1,414	1.0
602	Cellulitis with MCC	1,398	1.0
	Top 25 MS–LTC–DRGs	88,369	64.1
	Total	137,846	100.0

Note: MS–LTC–DRG (Medicare severity long-term care diagnosis related group), LTCH (long-term care hospital), MCC (major complication or comorbidity), CC (complication or comorbidity), OR (operating room). MS–LTC–DRGs are the case-mix system for LTCHs. Columns may not sum to totals due to rounding.

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

- Cases in LTCHs are concentrated in a relatively small number of MS–LTC–DRGs. In 2013, the top 25 MS–LTC–DRGs accounted for almost 65 percent of all cases.

- The most frequent diagnosis in LTCHs in 2013 was respiratory system diagnosis with ventilator support for more than 96 hours. Nine of the top 25 diagnoses, representing 42 percent of all cases, were respiratory conditions or involved prolonged mechanical ventilation.

Chart 8-17. The number of Medicare LTCH cases and users decreased between 2012 and 2013

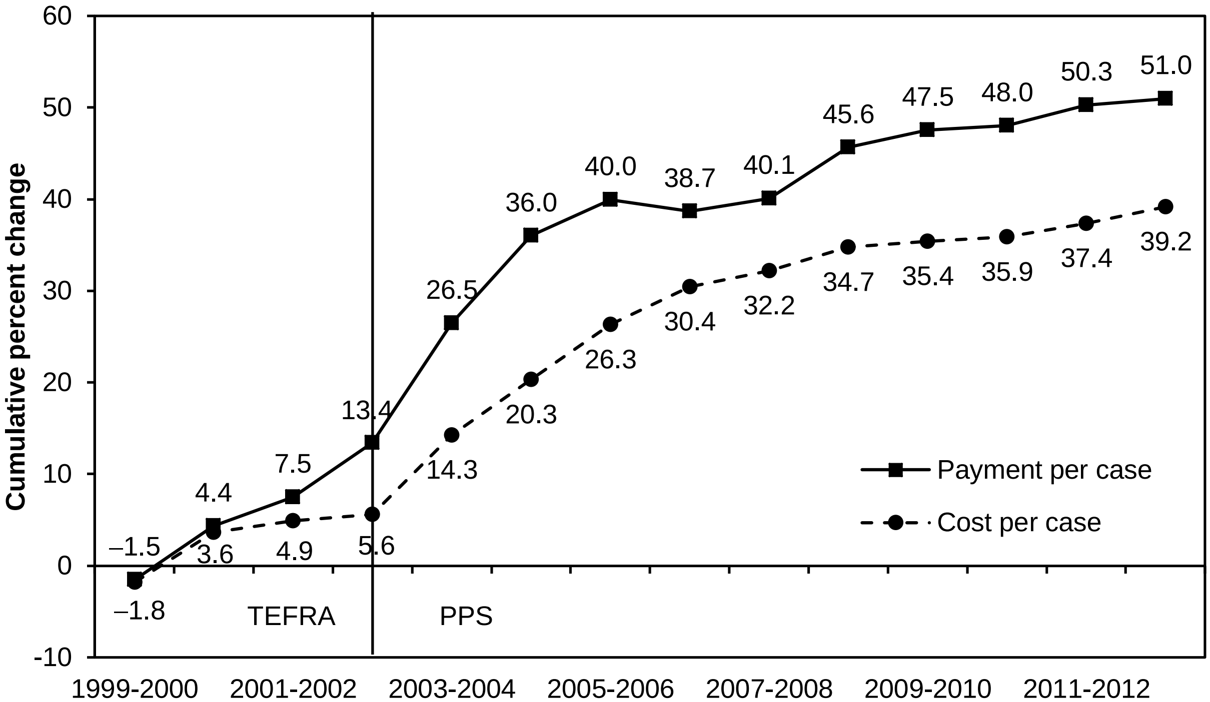
						Average annual change			
	2004	2005	2007	2012	2013	2004–2005	2005–2007	2007–2012	2012–2013
Cases	121,955	134,003	129,202	140,463	137,827	9.9%	–1.8%	1.7%	–1.9%
Cases per 10,000 FFS beneficiaries	33.4	36.4	36.3	37.7	36.8	9.0	–0.1	0.7	–2.2
Spending per FFS beneficiary	$101.3	$122.2	$126.5	$148.8	$147.6	20.7	1.7	3.3	–0.8
Payment per case	$30,059	$33,658	$34,769	$39,493	$40,070	12.0	1.6	2.6	1.5
Length of stay (in days)	28.5	28.2	26.9	26.2	26.5	–1.1	–2.3	–0.5	1.0
Users	108,814	119,282	114,299	123,652	121,532	9.6	–2.1	1.6	–1.7

Note: LTCH (long-term care hospitals), FFS (fee-for-service). Yearly figures presented in the table are rounded, but the average annual change column was calculated using unrounded data.

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

- Controlling for the number of FFS beneficiaries, the number of LTCH cases declined 2.2 percent between 2012 and 2013. The decline is due at least in part to a congressional moratorium that limited growth in the number of LTCHs.
- Between 2012 and 2013, the number of beneficiaries who had LTCH stays (users) decreased by 1.7 percent.

Chart 8-18. LTCHs' per case costs increased at a rate faster than payments in 2013



Note: LTCH (long-term care hospital), TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), PPS (prospective payment system). Percent changes are calculated based on consistent two-year cohorts of LTCHs.

Source: MedPAC analysis of Medicare cost report data from CMS.

- In the first years of the PPS, costs per case increased rapidly, following a surge in payments per case.
- Between 2005 and 2008, growth in cost per case slowed considerably, as regulatory changes to Medicare's payment policies for LTCHs slowed growth in payment per case.
- Spending growth between 2010 and 2013 slowed to 2.1 percent, in part because of mandated reductions in Medicare's LTCH payment rate beginning in 2011.

Chart 8-19. The aggregate average LTCH Medicare margin fell in 2013

Type of LTCH	Share of Discharges	2008	2009	2010	2011	2012	2013
All	100%	3.7%	5.7%	6.8%	6.9%	7.4%	6.6%
Urban	95	3.9	6.0	7.1	7.0	7.5	6.8
Rural	5	–3.2	–3.0	–0.2	2.9	3.5	2.4
Nonprofit	14	–2.5	–0.7	–0.2	0.4	–0.6	–1.7
For profit	85	5.3	7.4	8.3	8.4	9.0	8.4
Government	1	N/A	N/A	N/A	N/A	N/A	N/A

Note: LTCH (long-term care hospital), N/A (not available). Margins for government-owned providers are not shown. They operate in a different context from other providers, so their margins are not necessarily comparable.

Source: MedPAC analysis of cost report data from CMS.

- After implementation of the prospective payment system, LTCHs' Medicare margins increased rapidly for all LTCH provider types, climbing to 11.9 percent in 2005 (data not shown). Margins then fell as growth in payments per case leveled off.

- From 2009 through 2012, LTCH margins climbed as providers consistently held cost growth below that of payment growth.

- In 2013, the aggregate LTCH margin fell from 7.4 percent (in 2012) to 6.6 percent, primarily because of the first year of a three-year phase-in of the downward adjustment for budget neutrality and the effect of sequestration beginning on April 1, 2013.

- Financial performance in 2013 varied across LTCHs. The aggregate Medicare margin for for-profit LTCHs (which accounted for 85 percent of all Medicare discharges from LTCHs) was 8.4 percent. The aggregate margin for nonprofit LTCHs fell from 0.4 percent in 2011 to –0.6 percent in 2012 and then –1.7 percent in 2013. This decline was due to cost growth that exceeded growth in payments. Between 2012 and 2013, per case costs for nonprofit LTCHs grew almost twice as fast as costs for for-profit LTCHs (data not shown).